COMPLAINT FORM

All patient complaints are confidential. This report and any attachments are part of the Donald A LaPointe Health and Education Center Quality Improvement Program and therefore protected confidential documents under the law. All Complaints will be given serious attention. This complaint form will be forwarded to the Health Director, who will directly address your concerns.
Please write clearly. If needed, please use the back of this form.

Nature of Complaint:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Day_____Date_____Time_____ Of incident

Were there any witnesses to the incident? (Who may have seen or heard what happened?)
Name of Witness_____Location_____
_____

Where did this take place? ◯ Clinic Receptionist Area ◯ Medical Clinic ◯ Dental Clinic
◯ Behavioral Health ◯ Health Fair ◯ WIC ◯Transport ◯ Car Seat Clinic
◯ Other_____

What would you like to see happen regarding this incident?

_____
_____
_____
_____
_____

Person Submitting Complaint: Name:_____
Address:_____
Phone:_____ e-mail_____

Signature:_____Date:_____
(required for investigation and chart review)

Thank you for helping us to improve our services for you!